the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

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The Cover

One of the characteristic manifestations of schizophrenia is withdrawal from reality. The patient feels threatened by a complex environment and inadequate to meet the requirements of adaptation. As protection from personal devaluation, he envisions a situation in which he is both safe and capable. A discussion of the psychological aspects of schizophrenia begins on page 50 of this issue.

A concept of withdrawal is portrayed in the cover drawing by Joseph F. Schwarting.

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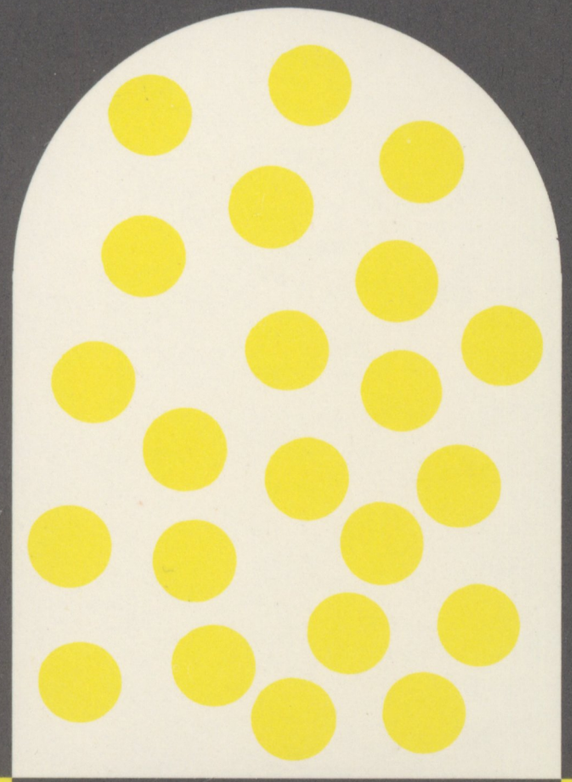

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Volume VII • Number 3 Summer, 1957

THE PSYCHIATRIC BULLETIN comes to you with the compliments of Smith, Kline & French Laboratories, as part of their mental health program. Our editorial policy continues to be wholly independent and our purpose remains to keep the physician informed on new developments in psychotherapeutics for use in everyday practice.

THE EDITORS

Contents

Psychotherapy

● ALTHOUGH PSYCHOTHERAPY was once considered only as a philosophical endeavor and a part of the art of medicine, it is now recognized as a part of the science of medicine also. Because of the vast amount of literature about the subject, physicians may have the impression of technical complexity and thus may be reluctant to use a discipline in which they feel inadequately trained. Then, too, many physicians distrust psychiatric techniques and may be disturbed by the necessity to treat patients with emotional disorders. In contrast to this pessimistic attitude, some physicians are over-enthusiastic about the benefits of psychotherapy and expect adequate and facile solutions for the most refractory emotional problems.

Admittedly, the principles of psychotherapy are not as easy to describe as the principles of hemostasis; nevertheless, they are also scientific. Psychotherapy can be simply defined as the personal interaction between physician and patient that accomplishes a planned therapeutic purpose. Since an estimated 50 per cent of patients have illnesses that are primarily psychologic, the success of therapy will in many cases depend upon the physician's ability to mitigate emotional disturbances. Obviously, practical management of emotional or psychologic problems should not be based on individual intuition and improvisation. Instead, the physician should utilize psychotherapeutics in a conscious and purposefully directed way.

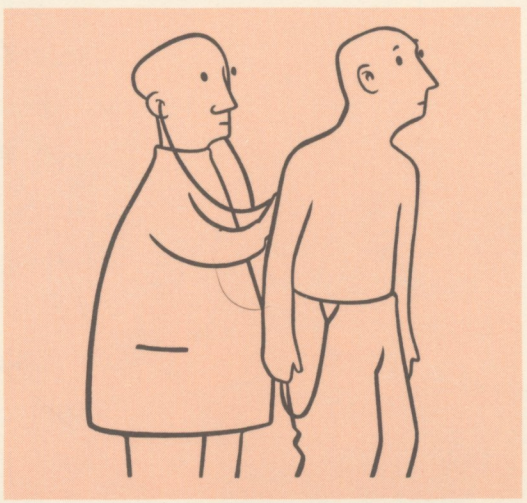
Techniques of psychotherapy

The two major kinds of psychotherapy are manipulative, as used by the nonpsychiatrist, and insight therapy, which is considered the prerogative of the psychiatric specialist. Manipulative or palliative therapy implies effecting a change in external factors, such as the patient's occupation or habits. By insight or interpretive therapy the patient is helped to become aware of the meaning of his symptoms and conflicts.

Before institution of treatment the practitioner must determine his exact purpose and which methods he will use. He should be familiar with the various techniques, so that his treatment will not be inflexible and stereotyped without regard for personality differences among patients.

The first procedure is establishment of a relationship of mutual respect, trust, and confidence. This rapport is increased by listening to the patient's account of his symptoms or other conditions important to him. Although it is necessary that the physician listen attentively and sympathetically, the interview may need direction if the patient talks with excessive circumstantiality or repetition. With carefully phrased questions, the physician can guide the interview without inhibiting or destroying spontaneity. Most important, the patient should be made to feel that the physician is interested in him as a person, and not just as a disordered organ system.

Support and reassurance can help the patient even during the first interview. Obviously, some tacit support is afforded by the physician's presence, manner, and expressed interest. As confidence in the therapist is developed, the patient's self-confidence is also increased. The patient must receive some reasonable reassurance that his distress can be alleviated, after which the physician can give him further support by clarification and instruction to help avert future distress. In general, however, this support and reassurance should be largely nonverbal. This is especially true of the overdependent patient for whom constant reassurance may cause exacerbation of symptoms and may actually prolong illness.



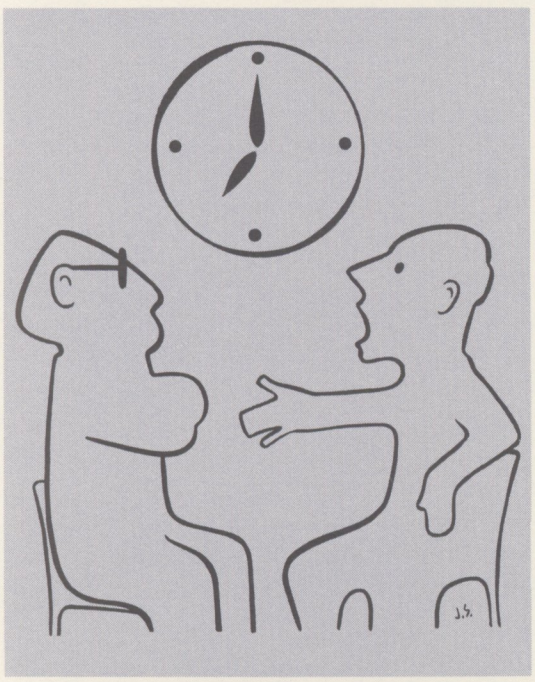
Organic disorders are first excluded

Probably *ventilation and catharsis* are the most effective of all the techniques. The patient must be allowed to describe his fears, doubts, resentments, and other disturbances, which process, of course, necessitates constant and subtle direction. After an adequate period of ventilation, during which much can be learned about the patient's personality and past difficulties, a discussion of the patient's present problem can be initiated. The period of ventilation accomplishes two objectives: the patient's descriptions help him to clarify his problems, and, by transferring them to the physician, some release of emotional tension is achieved. Acceptance by the physician thus frees the patient from constant suppression of feelings, and, in turn, increases his self-understanding and self-acceptance. Once the patient's circumstances are clarified, he can be helped to see how his own attitudes relate to his discomfort. The physician can then discuss the physical, emotional, and situational aspects of the problems to help the patient gain some degree of insight. Some didactic explanation of adjustive mechanisms may be necessary in order for the patient to understand how emotional

tension and anxiety can prolong physical symptoms. As the patient is made aware of the significance of his behavior, he is afforded a better opportunity for choice and control of it.

Suggestion is an important technique, but is somewhat limited in application since patients differ greatly in suggestibility. Obviously, specific verbal suggestions for improvement should be reasonable and optimistic. Suggestions should not pertain to major aspects of the patient's life such as marriage and divorce. They should also be kept to a minimum, as the more valuable aspect is the constant suggestion of hope and help inherent in the physician's general demeanor.

A major phase of psychotherapy is *re-education.* In many instances,



Ventilation need not be unlimited

through short-term re-education the nonpsychiatrist can help patients to learn new patterns of adaptation to familial, social, occupational, and personal needs. In most cases in which long-term re-education is indicated, however, psychiatric referral or consultation may be necessary. The major purposes of re-education are the substitution of knowledge for ignorance, the reduction of fear and guilt, comprehension and resolution of conflicts, devaluation of the secondary gains of illness, and direction toward new ideals and purposes. This procedure, of course, must also be a highly individualized one.

In psychotherapy, as in surgery, there are both major and minor procedures. The general practitioner could and should treat patients with some emotional illnesses; however, psychotic or near-psychotic patients require special treatment and cannot be consistently helped by general psychotherapeutic techniques. Unfortunately, not even every psychoneurotic patient is a suitable candidate for psychotherapy, since, in many instances, a neurosis is actually the only possible solution.

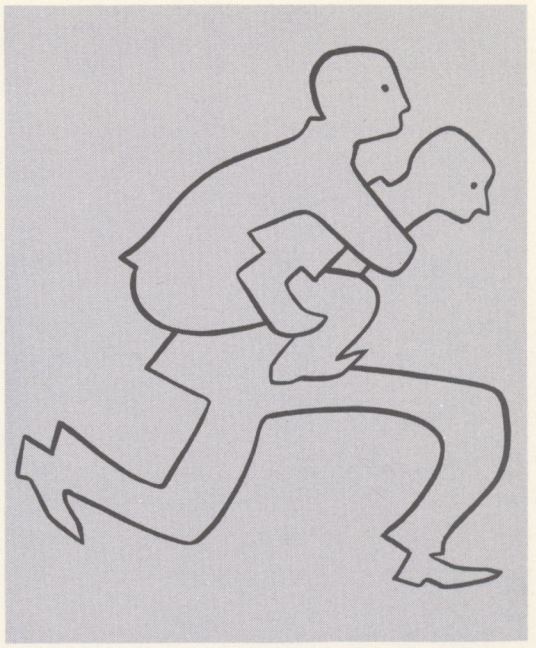
Patient prerequisites for psychotherapy

For satisfactory treatment, the patient must have certain assets. These must be evaluated according to the patient's intelligence, education, age, adaptability, ability to accept responsibility, environmental situation, motivation to be helped, ego strength, and the degree of secondary gain derived from illness. The intelligent individual, for example, can be extremely difficult to help, because he may consider any attempt at therapy as an intellectual contest with the physician. A conspicuous lack of education or sophistication may also be a serious deterrent to development of insight. Most important, the secondary gain derived from illness may nullify any incentive to change or to be helped except by the most superficial emotional support. Some individuals cannot or will not be freed from emotional conflicts and prejudices and cannot be taught to recognize basic aggressions and thus become less afraid of them. Indeed, if a patient does not really want to be helped, he cannot be directed toward attainment of healthy interpersonal relationships. For continuity of immediate and preventive psychotherapy, the physician, too, must have certain special personality and professional assets.

Physician prerequisites for psychotherapy

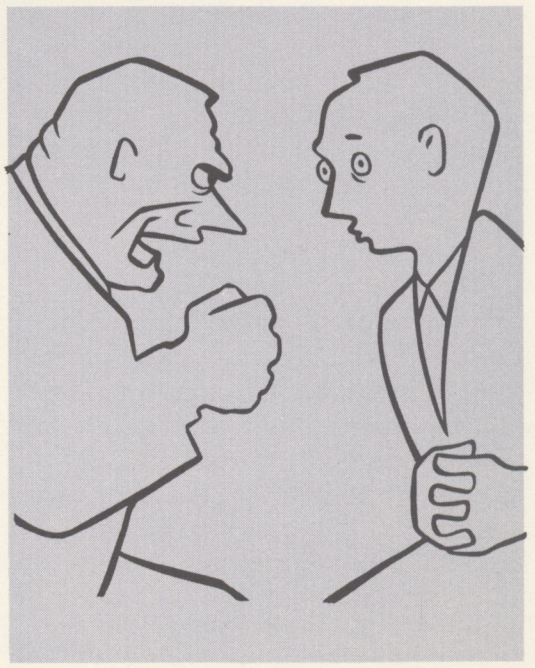
The therapist must first be able to listen to the patient without being reminded of his own experiences and without reacting in terms of his own problems. In brief, he must have attained sufficient emotional stability to help the patient to attain security and to find solutions that are relevant to the patient's problems, rather than those of the therapist.

Closely associated with this ability to listen is receptivity. This means



Support should not destroy initiative

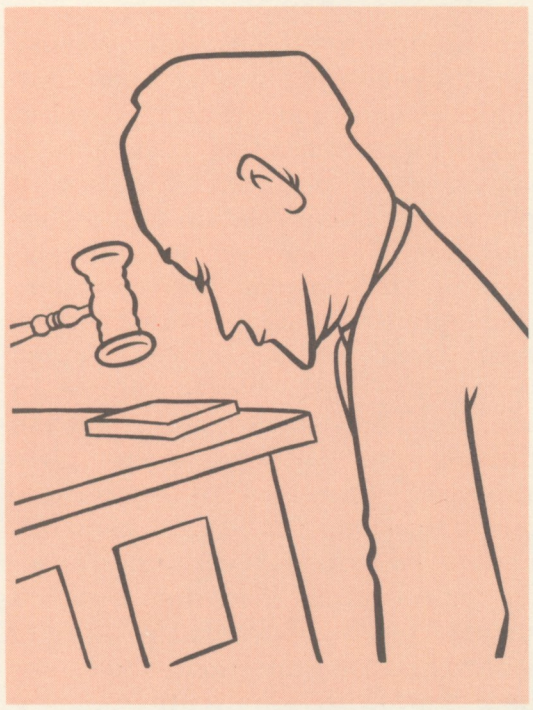
the ability to accept the patient's resentments and dissatisfactions, including expressions of disapproval of the therapist himself, and, sometimes, active, overt hostility. Since most physician-patient relationships are reenactments of the parent-child relationship, the patient often transfers to the physician his anger and resentment from previous experiences or from other authoritative figures in his life. This does not mean that the therapist must always accept unrestrained expressions of aggression, but at least he can try to help immature patients develop some capacity for restraint. Also, the physician should feel sufficiently secure to realize his own limitations, and recognize that, with some patients, only



Physician should maintain equanimity

limited adjustments may be possible. The physician should also be secure enough to accept a compromise, so that he does not personally become frustrated or develop doubts as to his ability to help the patient.

Additional prerequisites are insight, ability to evaluate the patient, and a considerable capacity for empathy. Even when the patient's emotional mechanisms are obvious, the physician should show no impatience. Similarly, disapproval of the activities and attitudes of the patient should not become obvious, since an attitude of acceptance of the patient is essential to successful therapy. The fact that a patient needs psychotherapy does not imply inferiority, and



The patient is counselled, not judged

without maintenance of a semblance of human equality, the value of collaboration will be lost. An authoritative approach may inhibit the patient's efforts toward maturity and ultimate achievement of self-reliance.

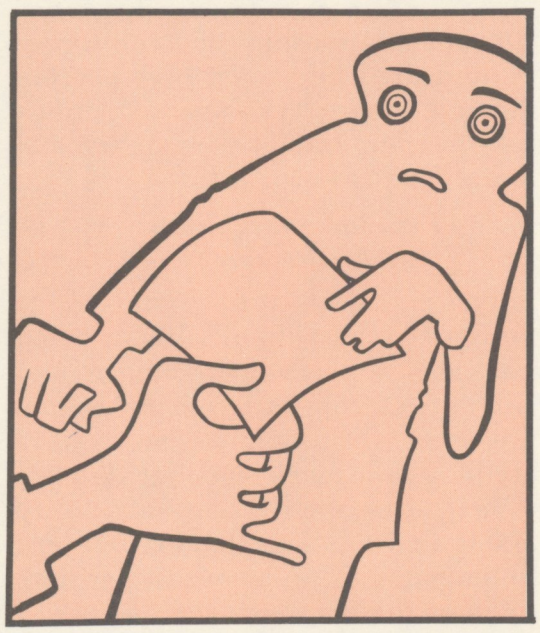
Finally, the physician himself must be relatively free from anxiety. This is especially important, since otherwise he may become afraid of or reluctant to listen to the patient's experiences. The anxious physician will be impelled to give premature reassurance because he is, himself, in need of just such support.

Alleviation of physical symptoms

Some patients may have severe psychosomatic symptoms and require

The patient should not be disparaged

symptomatic relief before psychotherapy can be attempted. Since patients are likely to recount their physical symptoms repeatedly, request further examinations, and demand immediate relief of immediate discomfort, the physician must be certain that the patient actually has a functional illness that can be relieved by psychotherapy. If the patient has been receiving psychotherapy and his symptoms become more severe, the therapist may himself become doubtful of the accuracy of diagnosis. For this reason psychotherapeutic techniques should not be used until all the mechanisms of dysfunction have been adequately investigated. Then the illness can be explained to the patient and reassurance and re-education offered him. If medicines are given, the patient should be told that the actual purpose is temporary and superficial relief until the real cause of disorder can be abolished.



Psychiatric referral may be necessary

Except for unusual circumstances, Stevenson discourages the use of sedatives for anxious patients. Sedation is contraindicated because it decreases the patient's motivation for ventilation, concentrates his attention upon his physical disorders, and, by relief of symptoms, makes progress difficult to evaluate. This author also condemns the use of placebos because their suggestive effects may relieve symptoms without permanent benefit. Then, too, use of placebos focuses attention on bodily discomforts and diverts the patient from examination of his emotional problems. There is also the possibility that the patient will discover the deception and this, of course, usually negates any success that may have been attained.

Conclusion

Since psychotherapy is a directive method of treatment, the knowledge of as many techniques as possible will facilitate therapy. In addition, the attainment of the ability to listen, of receptivity, and of emotional security will help the physician to improve his skill. With these prerequisites, the physician may be able to liberate the patient from neurotic behavior patterns and help him toward emotional health and maturity.

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Social Problems Of EPILEPSY

● Many epileptics, aided by adequate medical management, could maintain relatively normal and pleasant existences. With medication the occurrence of seizures may be controlled in a manner analogous to the diabetic patient's regimen. Of the epileptic patient's many needs, the predominant ones are understanding, individualized medical care, and social acceptance. Epilepsy is not a single entity, although in public opinion epileptics have been grouped together. Considerable progress has been made in medical understanding of epilepsy, but further education of the general public is necessary. For example, three of the most significant components of an integrated life, education, employment, and marriage, are often unattainable for the epileptic. Further, although legal statutes restrict certain general rights of the criminal, the insane, the morally and mentally defective, and the epileptic, the latter does not belong in this list.

The safety of society is, of course, a principal concern, and there are several circumstances in which the epileptic's activity should be restricted. For example, permission to drive an automobile must be considered on an individual basis. Many controlled epileptics are able to drive with safety; others should be restricted in this activity. Medical appraisal and recommendation for each individual patient should be made, however, rather than prohibition of privileges of an entire group.

The American Branch of the International League Against Epilepsy estimates the number of known epileptics in this country to be one in every 200 persons. Other investigators have reported the incidence to be 1,500,000. Patients who manifest seizures without demonstrable specific organic lesions are generally considered to have idiopathic, or primary epilepsy. Secondary, or symptomatic epilepsy is considered a consequence of known pathologic change.

Psychological factors are inherent in both disease states. Caveness has stated that emotional problems may occur as reactions to seizures, may precipitate individual seizures, and may affect the pattern of seizures. Although the etiology is unknown, the fact that the patient experiences problems of anxiety, uncertainty, and fear, as well as shame, bitterness, and secrecy is indisputable. Most investigators, however, have discounted the theory of specific traits as characteristic of all epileptic patients.

Education

Academic education constitutes one of the foremost needs of the epileptic, primarily to compensate the physical handicap, to aid in social development, and to stimulate interest in adjustment. The prevalent concept of mental defectiveness and unpleasant personality must be resolved in order to modify the entrance restrictions which exclude epileptics from many schools. The theory that mental defectiveness is always concomitant with epilepsy has been disproved. For example, a report of the intelligence tests of 600 epileptic patients showed an average score of 109. Twenty-eight per cent of the group had scores of 120 or higher.

Questionnaires regarding acceptance of educationally qualified epileptics were sent to 1,676 colleges and universities. Replies from the school authorities were indicative of varied acceptance according to the category of school. For example:

School category	Admission refused
6 military schools	100 per cent
102 theological seminaries	27 per cent
228 teachers' colleges	24 per cent
42 art and music schools	19 per cent
121 technical schools	17 per cent
436 junior colleges	10 per cent
741 arts and science schools	10 per cent

In each school classification, the directors of the largest number of schools replied that there were no rules concerning the admission of epileptics. Many schools' authorities asked for guidance, and expressed the wish that family physicians be more explicit in their recommendations.

Employment

The known epileptic is often refused employment because of his disorder, or is permitted to perform only sedentary work. In many instances, this is an unnecessary restriction. One major reason offered for refusal to employ epileptics is that the employer's insurance rates under the provision of the Workmen's Compensation Law would be increased in accordance with the supposed high accident rate of epileptics. An unusually high accident rate has not been observed in cases of known employed epileptics. The American Federation of the Physically Handicapped has suggested the provision of a special fund through assessment of 0.1 per cent of wages. From this fund compensation could be paid for injury incurred as a result of the employee's disability. Lennox has suggested that members of the Physicians League Against Epilepsy collect and publish data to show the low accident incidence of epileptic employees with medical treatment and job placement individualized for each patient.

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SOMNAMBULISM

THE WORD "SOMNAMBULISM" ordinarily connotes sleepwalking, although it may also refer to motor activity performed during certain hypnotic states. Sleepwalking most often occurs during childhood and adolescence. When this particular kind of sleep disturbance continues in adult life, in most cases the onset is found to have occurred about the time of puberty. At any time of life somnambulism is probably associated with dreaming, although sleepwalkers usually cannot remember the dreams after awakening from such episodes.

Organicity

Pierce and associates have reported 34 instances of naval personnel who were somnambulists. Electroencephalographic and psychiatric interview studies were made with the purpose of possible rehabilitation. Of the 34 recruits, 7 were found to have abnormal EEG's; complaints referable to the genitourinary system were cited in 18 cases; 19 gave family histories of sleepwalking; and 21 were enuretic. These authors point out that lesions of the central nervous system can cause disorders of urinary function. The number of patients who had relatives with the same disturbance is suggestive of a familial factor. The patients who had abnormal EEG's may have had hereditary cortical disturbances, and the genitourinary disorders may have been secondary to impairment, probably metabolic, of the central nervous system. Since the metabolism of the cerebral cortex is still not wholly understood, it may be that a biochemical aberration is the causative agent in instances of the sleep disorders.

Dissociation

Somnambulism, like dreaming, is a dissociative reaction, which Laughlin describes as "coordinated physical activity which has been split off or dissociated from the normal stream of consciously directed and purposeful physical activity." An individual who walks in his sleep has probably, then, not only the obvious capacity to dissociate motor activity but also a significant degree of suggestibility. The somnambulism may become manifest simply because of a physiologic need, or it may be an expression of unconscious conflict. The sleepwalker's facial expression or the direction of walking may sometimes be indicative of the content of his dream or even the reason for the dissociative reaction. The psychologic purpose may be a sort of search for a specific object or for an abstract or generalized wish, an escape or a return. With children, sleepwalking more often seems to be a running to the parent or a running from punishment. Adults with unresolved or ambivalent feelings toward parent figures may be demonstrating the same sort of unresolved need.

The motor activity

Somnambulism has been called the opposite of cataplexy. Patients commonly are able to dress themselves, open doors, climb stairs, and perform other such activities while asleep. Although many somnambulists may be apprehensive about hurting themselves, apparently few actually ever incur injury. Indeed, the coordination of most sleepwalkers seems to be not exceptional, as is sometimes asserted, but adequate. In one reported episode a young patient climbed out his window, on the 12th floor of an apartment building, walked on an 18-inch-wide ledge to another window, climbed in it, and returned to his own apartment and bed without waking. A witness told of being afraid to arouse him for fear of causing him to fall. It is, however, unusual for a sleepwalker to endanger himself, and Laughlin commented upon this individual's uncommon physical proficiency, as well as his ability to look out for his own safety even while he was known to be in a dissociative state.

The personality of the individual who in adult life still walks in his sleep seems to be that of the immature and the personally inadequate. At least, these are among the characteristics inferred from the psychiatric interviews and family histories. Patients who are subject to somnambulistic episodes customarily seem to have adjusted rather well to their life situations, are non-aggressive, socially well-behaved, and have limited ambition. Such individuals perhaps overcompensate a lack of self-confidence in scrupulous conformity and in avoidance of competition. This factor could account for the lack of interest in sports and the humble ambitions of sleepwalkers studied by Pierce and others. Docility may serve to keep the sleepwalker from social or emotional pressures and may also afford gratification for dependency requirements.

Stress

Besides somnambulism as an indicator of concealed conflict there is also the factor of immediate stress. Individuals who have not been troubled by somnambulism since childhood are known to have recurrences during times of change or emotional disturbance. This manifestation may be considered part of the personality's reaction to crisis. In some instances the patient will recognize in his immediate situation the reason for the disruption of normal sleep. In others the particular threat to the ego will be unknown to the patient and the extent or seriousness of the problem such that he will resist any effort to stop his sleepwalking. In the group of 34 patients studied, 24 thought that worries or fears concerning the future, financial problems, and grievances from the past induced the somnambulism. Some patients related the initial experience of sleepwalking or the first

remembered one to emotional crises in childhood, subsequent ones to situations that produced anxiety. According to Pierce and Lipcon, "The sleepwalkers have many unresolved oedipal problems and intense sibling conflicts. The development of an actual episode of sleepwalking is commonly related to emotional problems in which the man seems to have a need to run away from the bed (as a place of temptation) or to walk to a place of protection."

Therapy

As somnambulism is not a pathologic entity so much as a symptom of disturbance the physician will have first to help the patient to some recognition of the emotional import. When the problem is an environmental one it may be possible through discussion to afford the patient an outlet for expression of his vexations or grievances. Physical examination can be reassuring, as can the discussion afterward of the clinical findings. If the patient has a fixed idea of a causative factor, even if it seems an unlikely one, the physician may be able by advice either to relieve him of fear or make some recommendation for his comfort. Changes in sleeping arrangements or dietary adjustment may be suggested. If the somnambulistic episodes have occurred only recently or after years without any such manifestation, and if there is an obvious immediate problem, the patient may need little help. If, however, the sleepwalking continues and, cycle fashion, brings about further embarrassment and anxiety, more intense psychotherapeutic measures will be required.

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MARRIAGE COUNSELING

● Of the 30,000,000 married couples in this country, an estimated 7,500,000 will be divorced. The proportion of marriages that terminate in divorce has been variously reported, but the minimal probability is one in five. Since family security is essential to our culture, these figures represent an undesirable trend. Unfortunately, there are relatively few persons that are well prepared to offer adequate marriage counseling.

The American Association of Marriage Counselors and the National Council on Family Relations appointed a committee of representatives to determine the minimum qualifications requisite for counsel service. Educational requirements, clinical experience, and personal qualifications have been defined by the committee, and these same groups have organized a board of certification, and established standards for counseling clinics. Their intent is to provide reliable marriage counsel, and eliminate untutored advisors.

Marriage counseling is a different service from the family counseling provided by social agencies. Assistance in such matters as budgeting, housing, vocational guidance, and parent-child relationships may be obtained through accredited agencies and child guidance clinics.

Laidlaw has defined marriage counseling as ". . . a form of short-term psychotherapy dealing with interpersonal relationships, in which problems relating to marriage are the central factor." The therapy is conducted with the counselor as an active participant in the discussions. If, in the course of treatment, more involved psychotherapeutic techniques seem to be needed it may be necessary to refer the patients to a psychiatrist for further help.

Marriage counseling may, of course, be premarital or postmarital. Premarital counseling is sufficiently related to education to be accepted as such throughout this country. In the United States, 596 colleges provide undergraduate courses in marriage and family relations. Such courses offer an excellent means for presentation and discussion of fundamental concepts of marriage. In most instances, however, the classroom atmosphere is not conducive to expression of individual opinions, and the extent of an individual's knowledge does not necessarily preclude development of adverse attitudes.

Three major religious groups in the United States have established organizations which offer assistance in marriage preparation. The Commission on Marriage and the Home was founded by the Protestant churches; the Family Life Bureau is maintained by the Catholic church; and the Institute on Marriage and the Family is supported by members of the Jewish faith. All three groups have approved medical service in conjunction with marriage counseling. During the past twenty-five years, many restrictions in regard to medical service have been resolved, with religious and medical teaching no longer considered incompatible.

The general practitioner is consulted more often than the specialist for premarital interviews and examinations. Forty states and two territories require serologic test reports and some written evidence, such as a health certificate, of physical examination. The premarital consultation may be conducted in much the same sequence as any other consultation. Individual attitudes must be ascertained and particular questions answered. The physician may introduce such topics as family planning, particularly with younger couples. Since the first year of marriage is cited as one of the most difficult in adjustment, the physician should avoid haste or assumption in the premarital interview. Discernment and thoughtful counsel given during the premarital interview may help prevent some of the adjustment difficulties.

The physician may also be consulted about postmarital conflicts. This selection of a physician as advisor may be attributed to his status as an informed and reliable counselor. A physician may also be consulted because of physical disorders that sometimes result from or sometimes contribute to maladjustment in marriage. Most investigators agree that separate interviews for husband

and wife are preferable. Each person tends to speak more freely, and is more likely to admit his own inadequacies when he is not in the presence of the other. This method also eliminates the possibility of the physician's committing himself in agreement with one person to the exclusion of the other. Should therapy be needed for both husband and wife, the referral of one patient to a colleague is recommended. Martin and Bird reported this procedure as the *stereoscopic technique*. Meetings of the two physicians to discuss, with the consent of the patients, the problems as presented by each individual enabled the physicians to recognize distortions of reality more readily.

In order to provide effective counsel, the physician should refrain from imposing his own religious beliefs or moral standards. For example, a decision concerning divorce must obviously be made by the patient. The responsibility of the counselor is to help the patient to a realistic review of his problems, to prevent hasty action, and to help the patient reach a conclusion which will best serve the marriage. The purpose of marriage counseling is the preservation of the marriage through mature emotional adjustment of both husband and wife. Occasionally, however, the immaturity and instability of one individual or both may be such that there can be no agreement. If the decision for divorce is made, the physician may help the persons to understand the reasons for failure, and possibly may help them toward maturity during this experience.

Many marital conflicts result from emotional maladjustment which antedated marriage. The maladjustment, in turn, may have been the result of faulty upbringing. Competent marriage counseling may help to interrupt the succession of disturbances from one generation to the next by assisting persons not only to adjust to each other but also ultimately to become more adequate parents.

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Book Reviews

● The Death and Rebirth of Psychology. *By I. Progoff, Pp. 275. Price $4. New York, The Julian Press, Inc., 1956.*

For evaluative purposes depth psychology must be interpreted according to the history of the four scientists who developed the theory. In this volume the author presents a study of the founder, Sigmund Freud, and of the contributions and changes made by Adler, Rank, and Jung. The work of these four men culminated in a modern philosophy widely different from that of Freud but remaining an obvious outcome of his theories. The Death and Rebirth of Psychology opens with a reaffirmation of essential spirituality in human experience as fundamental. The theses of the four psychologists are examined historically and their necessary integration established. The complementary function of each type of psychologic reasoning becomes apparent in this hopeful and scholarly exposition of the whole.

● The Importance of Overweight. *By H. Bruch, M.D. Pp. 438. Price $5.95. New York, W. W. Norton & Company, Inc., 1957.*

In this book some clarification is attempted of the clinical findings and therapeutic procedures in constitutional or alimentary obesity. Dr. Bruch points out that there is difficulty as well as danger in grouping together under one designation clinical instances of a condition that is both variable and complex. The physiologic and emotional causes of "simple" obesity obviously require scrupulous evaluation before therapy is initiated, and the author includes discussions of hereditary and social factors, metabolic variations, and practical management of patients. The volume is illustrated with graphs and tables. There is a detailed index, and a list of 153 references.

● The Great Physiodynamic Therapies in Psychiatry. *Edited by Arthur M. Sackler, M.D. and others. Pp. 190. Price $5.75. New York, Paul B. Hoeber, Inc., 1956.*

This collection of articles was first published in *The Journal of Clinical and Experimental Psychopathology & Quarterly Review of Psychiatry and Neurology*, Volume 15, numbers three and four, 1954. Fortunately, the papers from the symposium are now available with some emendations in this useful and instructive volume. The subtitle "An Historical Reappraisal" is particularly informative, as the authors represented include the originators of most of the current therapeutic procedures.

There are bibliographies with the papers in this group, an index, and short biographies of some of the authors. The first paper, by F. Marti-Ibanez, M.D. and associates, is of especial interest, as it affords the background of the development of organicistic reasoning.

● Straight to the Heart. *By G. Lawton, Ph.D. Pp. 347. Price $5. New York, International Universities Press, Inc., 1957.*

This volume, intended for the layman, is a first-person account of the experience of surgery. The author is himself a psychologist and makes clear the implications to the frightened individual of cardiac surgery.

Psychological Factors

According to Arieti, "Schizophrenia is a specific reaction to an extreme state of anxiety, originating in childhood, and reactivated later in life by psychological factors". The etiology of this specific reaction has not been clearly delineated, although both organic and functional bases have been recognized. Neither basis, however, has been proved exclusively causative. It may be that organic and functional causes exist in combination with additional genetic, environmental, and constitutional factors, as well as personality predispositions. Schizophrenia may actually be several different diseases with a particular cause for each disorder instead of a single disease entity. Schizophrenia may also occur in conjunction with other psychotic disturbances, such as manic-depression, paranoia, and involutional reactions.

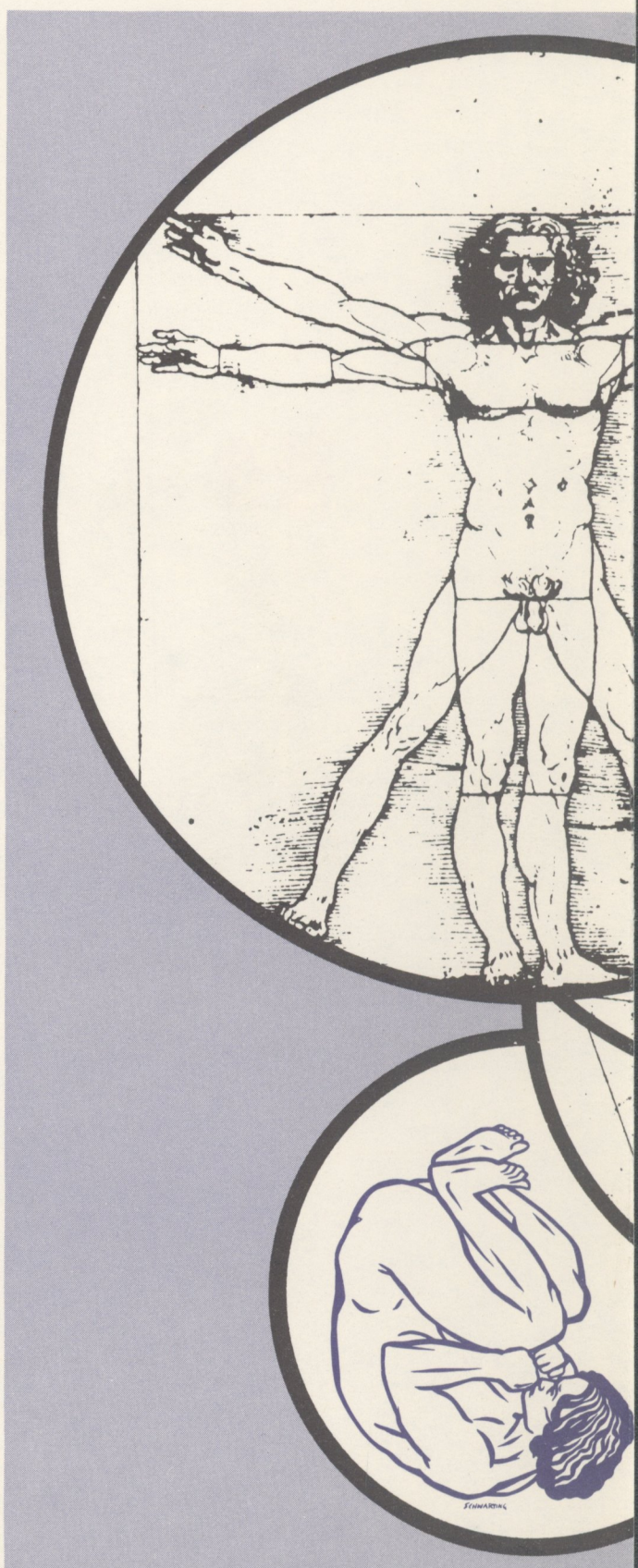
Many investigators have contributed to the knowledge of schizophrenia. Kraepelin described the symptomatology, and suggested use of the term *dementia praecox*, with subdivisions of catatonic, hebephrenic, and paranoid reactions. Bleuler first used the term *schizophrenia*, and added a fourth subdivision of classification, that of simple schizophrenia. He discussed the characteristics of split psychic function and association disorder, and suggested the terms *autism* and *ambivalence*. An advocate of Freud's theories, Bleuler was interested in the psychological explanation of the symptomatology, although he did not entirely refute the possibility of an organic origin. Bleuler and Meyer are generally credited with initiating the present psychological concepts of schizophrenia.

Meyer's advocation of longitudinal study of the schizophrenic patient emphasized the behavioral approach. According to Meyer, the habit deterioration or faulty habit substitution in schizophrenia varies only in quantitative degree from prepsychotic habit disorders and the differentiation between faulty habits and incipient schizophrenia was not clearly defined. However, Meyer's reaffirmation of the psychological factors influenced later investigators.

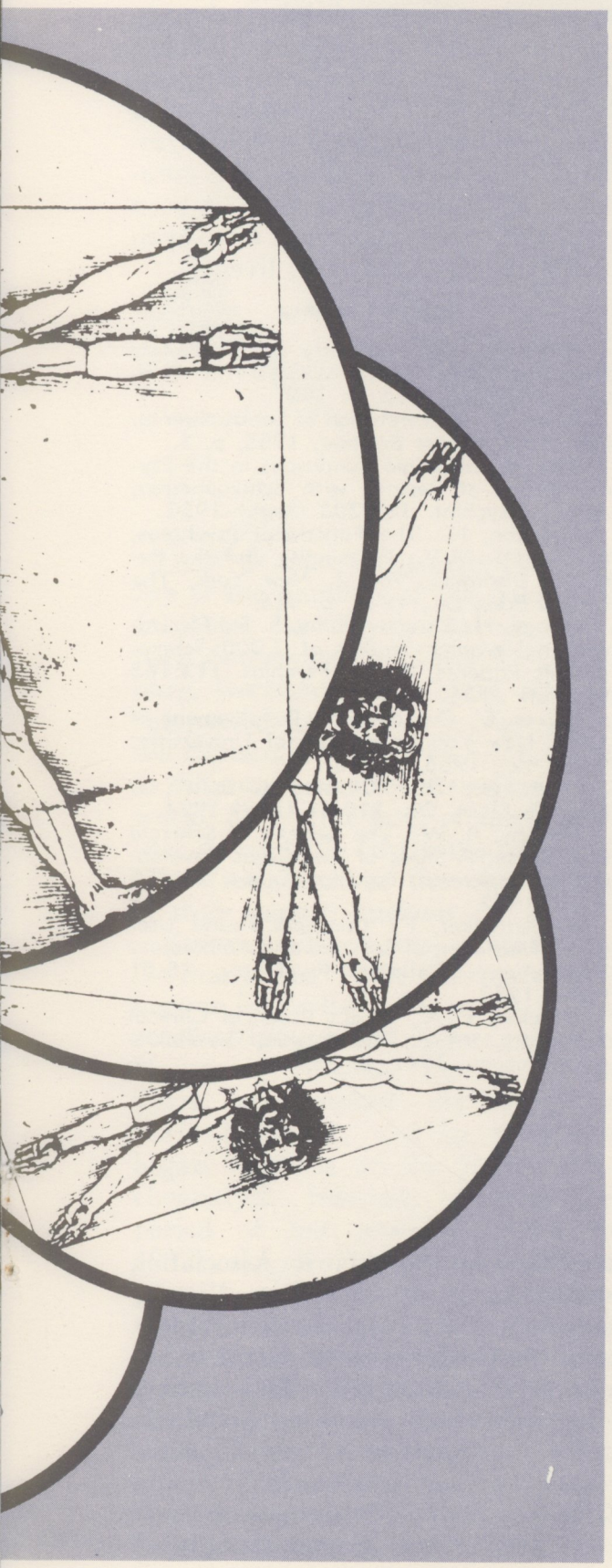
Freud, as founder of the method of psychoanalysis, also contributed to the study of schizophrenia. For example, Freud's interpretation of the unconscious, and his explanations of regression, projection, and transference were recognized as pertinent. Most significant, perhaps, was his concept of symbolization which contrasted with Meyer's realistic interpretation. Jung described the personality of the schizophrenic as introverted and was the first to attempt explanation of the etiology of schizophrenia as psychosomatic. He stated that emotional disturbances produced a toxin injurious to the brain.

Sullivan observed, as earlier investigators had, that interpersonal relations had considerable effect upon the development of schizophrenia. He wished to place the psychological study of schizophrenia on a recognized basis of social science.

Various explanations have been offered for the actual manifestations of schizophrenia. The schizophrenic patient has been said to find reality harsh, painful, confusing, and destructive to effort toward emotional survival. Adaptation to the process of living makes demands upon him with which he is unable to comply. The concept of himself as valueless is unacceptable to him so that he, therefore, devaluates reality and diverts his thinking to fantasy, delusion, and hallucination. This process may become, finally, a complete withdrawal. Until a patient has



in *Schizophrenia*



reached the status of dementia, however, he continues to feel the pressures of reality. His fantasies may be pleasant, but unless wholly accepted, they do not provide sufficient protection from anxiety. Strecker and associates cite this period of preacceptance while reality still obtrudes as the stage when panic and suicide occur. This is also the period during which therapeutic measures may be effective. As long as the patient senses reality, there is at least some possibility of communication.

Communication with the schizophrenic is difficult because of his illogical reasoning. He may select a particular attribute of an object, and identify this object with another only on the basis of a similar attribute. For example, a chair may be identified with a dog because both have legs. The identifying link between seemingly dissimilar ideas or objects is often not readily apparent. For example, the schizophrenic patient makes no distinction in continuity of time, relativity, or between animate and inanimate matter. His expression, therefore, may result in the "word salad" regarded as characteristic of schizophrenia. However, even in the most bizarre verbalization there may be some correlation.

The regression of the schizophrenic patient has been compared to reactions observed in tests of lower animals. For example, rats that were subjected to mild electrical current in the floor of a cage sat on their hind legs to protect themselves until they learned to shut off the current by pressure on a lever. They continued to do this until the lever also was charged with electricity, whereupon they reverted to the previous less effective method. In much the same manner, the schizophrenic patient adopts regressive mental mechanisms although he does not maintain the integration of the level to which he regresses. This inability to integrate causes further frustration and further regression to a level, finally, where cognizance is not possible.

Theoretically, schizophrenia may occur at any age. A child may evidence such signs as withdrawal and lack of interest in his surroundings. Of course, other childhood disorders may produce symptoms similar to early schizophrenic manifestations, but the possibility of schizophrenia should be considered in instances of abnormal behavior. Adolescence is the period when schizophrenic manifestations are most often displayed. The reaction at this age may result from experiences of earlier childhood, and may be precipitated by emotional disturbances during adolescence. The patient who develops schizophrenia later in life frequently has a history of preceding schizoid symptoms, either unrecognized, or not sufficiently disturbing for him to have consulted a physician. Usually the onset of schizophrenia is gradual, although occasionally a sudden psychotic episode may occur in an individual who had shown no previous acute behavior disorder.

The patient's first recognition of abnormality may be realization of vague but frightening changes in himself which he does not understand. He may not believe this to be a fault within himself; but his distrust of others, the fact that his expressed ideas do not evoke an expected response, his inability to concentrate upon work, or feelings of unreality may cause him to seek help.

More often, peculiarities of behavior are noticed by persons associated with the patient. Such manifestations as day dreaming, withdrawal, lack of group identification,

inappropriate reactions, and repeated purposeless activity may be reported by family or associates.

The family physician may first detect early signs of schizophrenia. Hypochondriacal complaints are not unusual in the schizophrenic patient, and displaced apprehension is characteristic. For example, Aldrich cited the remarkable terms in which a young man stated his complaints. The patient said his chest felt as though it contained a large amount of pain-producing jelly, his head contained a mass of fluid, his right eye was decreasing in size, and his hands were shrinking. Despite the unfortunate significance any of these complaints might have, the patient's chief concern was the loss of a small amount of hair around a mole over his ear.

Complaints may not be obviously unusual. The physician may discern only vague discrepancies in the patient's manner, attitude, posture, or behavior. Difficulty in communication with the patient, or in establishment of rapport may be another indication. The family physician is in a particularly advantageous position to detect early signs of schizophrenia, since usually he will have known the patient and his family over a period of years.

Progression of schizophrenia is marked by an increase in the degree of abnormal behavior. For example, a patient whose early manifestations had included inability to assert herself and fear of displeasure progressed to a stage where she would assume one position, and not move at all. It became necessary for her family to feed her, lift her, and provide complete physical care. The patient stated that she had small particles on the surface of her skin, and that if she moved even slightly the particles would be dislodged and fall to the floor. This explanation provided a basis for avoidance of activity in which she would have to make decisions, and might make mistakes.

Hospitalized schizophrenic patients exhibit various symptoms of disease progression. In some patients there may be inappropriate laughter, hyperactivity, and antagonism toward others. In contrast, other patients withdraw, sit alone, and show no interest in individuals around them.

The voracious appetite of schizophrenic patients has been described by several investigators. Patients literally grab and clutch at food. Preferred foods are taken first, consumed entirely, then second choice food is taken, and the succession continues until everything edible has been consumed. This is a relatively late manifestation, and usually occurs after a period of disinterest in food.

Later manifestations include ingestion of nonedible objects. Autopsy studies of schizophrenic patients have shown in the intestinal tracts such articles as stones, pencils, spoons, ink wells, shirt collars, and almost any foreign body small enough to be swallowed. Obviously, the patients occasionally die of intestinal obstruction. Deliberate retention of excreta and coprophagia may also be evidenced. In addition to swallowing objects, patients may collect articles to store in secret places.

Terminal regression may be further characterized by apparent insensitivity to pain. Pinprick, flame, or ice applied to sensitive areas evokes no local recoil or general response. Some investigators have reported this sign in earlier stages of schizophrenia, but not to as great a degree. Patients who exhibit insensitivity to pain may, however, react to olfactory stimulation. Although the patient retains this sense, he is not guided by it. Accidents, such as burns, which occur frequently at this stage are attributed, in part, to lack of pain perception.

Since the exact etiology of schizophrenia has not been determined, therapeutic measures are also the subject of some controversy. For many years, schizophrenic patients were not believed to be amenable to treatment. The patients' withdrawal made establishment of rapport difficult. However, more than one investigator has reported patient response to a therapist who is able to convey sympathy and understanding. The curability of schizophrenia has not been proved, but many patients have been helped to resume normal lives.

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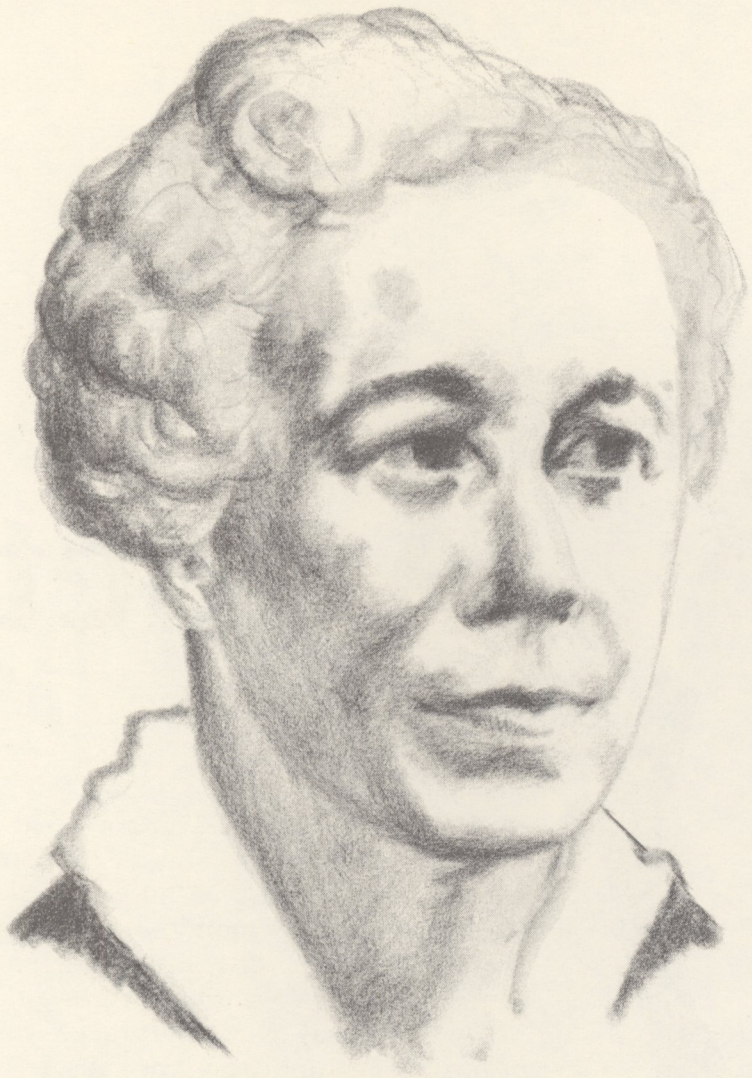
Glossary . . . . .

The Nomenclature Committee of the American Psychiatric Association published in 1952 a manual of standardized terms in which the disorder designations are grouped according to association with organic disturbance. In the manual, *depressive reaction* is one of the psychoneurotic disorders, all of which are characterized by consciously perceived anxiety. This anxiety may be relieved by direct expression, or the patient may resort to ego defense mechanisms. Depressive reaction is defined as a reaction by which partial relief from anxiety is obtained by depression and self-depreciation.

Future issues of *The Psychiatric Bulletin* will include definitions of terms as listed in the "Diagnostic and Statistical Manual for Mental Disorders."



Karen Horney

KAREN DANIELSEN HORNEY, one of the founders of the American Institute for Psychoanalysis, was born September 16, 1885, in Hamburg, Germany. As a child, she accompanied her father, a Norwegian sea captain, on many of his voyages to different countries throughout the world. She wrote later of the particular interest she felt in the people of each land, and in the observation of their various customs.

Karen Horney was educated in Germany. In 1909, she married a lawyer in Berlin, and, in 1913, she received her medical degree at Berlin University. During the next four years, she studied psychiatry at Berlin-Lankwitz, and in 1918 she began teaching at the Berlin Psychoanalytic Institute. During the period of her teaching (1918 to 1932), she also maintained a private practice, and was active in international congresses. Karen Horney's publications at this time were concentrated upon the subject of the psychological problems of women.

Dr. Horney's husband died in 1925, and in 1932, she and her three daughters came to the United States. She became associate director of the Chicago Psychoanalytic Institute and two years later became a member of the faculty of the New York Psychoanalytic Institute. In 1941, the American Institute for Psychoanalysis was founded, and she accepted the position of dean which she held until her death on December 4, 1952.

In addition to her work as a teacher and a therapist, Karen Horney was the author of several books and articles. Among her more significant titles between 1937 and 1950 were, *The Neurotic Personality of Our Time*, *New Ways in Psychoanalysis*, *Self Analysis*, *Our Inner Conflicts*, *Neurosis and Human Growth*, and *The Struggle for Self Realization*. Seven years after she came to the United States, she wrote "The greater freedom from dogmatic beliefs which I found in this country . . . . gave me the courage to proceed along lines which I considered right."

She taught and practiced according to Freudian concepts, with the addition of corollary theories of her own. She concurred in the fundamental thesis of unconscious forces, but she also believed that other factors, particularly cultural influences, were significant in the development of neuroses. She did not consider all neuroses to originate in sexual conflict, or to result from recurrent infantile fixations. Horney explained the basic need for growth and maturity as inherent in all individuals. Neuroses, she stated, result from distorted development in the process of growth. The distortions are a consequence of disturbed relationships with other persons. She believed that through analysis the individual could be helped to supplant his neurotic defenses with normal reactions, and be freed to continue growth.

Horney expressed the belief that "man can change and go on changing as long as he lives." For all of her professional career Karen Horney maintained an intense interest in helping people, faith in individual ability, and belief in the effectiveness of the psychoanalytic procedure as an important therapeutic measure.

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Anxiety

● Childbearing is a major experience for women. This particular truism is important because the altered or affected emotional attitudes that accompany this human experience may be forgotten. With improved medical care the incidence of physical complications as causative of neurosis has been greatly reduced. The incidence of postpartal psychosis is low. Yet, anxiety, depression, and exacerbations of domestic conflict remain common. Kummer said, "Pregnancy and childbirth are the most rapid and dramatic anatomic and physiologic changes to occur in the course of normal life processes. As might be expected, the emotional reverberations are of comparable magnitude. . ." In one survey in Great Britain the incidence of severe psychoses after childbirth was estimated to be 14 to every 10,000 confinements, but instances of emotional reactions, neurotic complications, and disorders of psychogenic origin are less readily determined. The obstetrician or gynecologist cannot know which patients are particularly vulnerable, as expressed fears or opinions of prospective confinement may have little to do with the actual reaction to pregnancy. It is not that patients commonly mask their actual feelings so much as that they are not aware of them. Because in our culture a particular group of attitudes is associated with parturition, many patients may subscribe vocally to the convention or be literally unaware of the significance of their own not unnatural misgivings.

Pregnancy is ordinarily construed

Reactions in Pregnancy

as a happy circumstance, and usually is. Even when conception is unwelcome, the gestation period serves a preparatory purpose and, commonly, patients are ready for delivery physiologically and psychologically. The occurrence of disturbance, illness, depression, or anxiety is, like normalcy, dependent upon the individual patient's personality structure.

A primipara has literally been in preparation for this experience of pregnancy from the time of playing with dolls. Her reaction will be conditioned by her relationship to her mother and husband, by the nature of instruction as to sexual function and parturition, and by the degree of her maturity. A patient who has successfully separated herself from her parents, worked out a satisfactory marital relationship, and, seemingly, evolved adult social or economic adjustments may nevertheless have acute anxiety which jeopardizes her own and subsequently her child's physical and emotional health.

Reactions to pregnancy

In any instance the patient's reaction to pregnancy is conditioned by her husband's reaction and financial circumstances, her acceptance of femininity, and her physical well-being. Women who have remained dependent and immature in marital relations may find in pregnancy a threat of displacement. In instances of financial strain, the patient is doubly threatened, as her husband's reaction may also be affected. Haas commented that every pregnant woman will wonder "to what extent pregnancy will interfere with her personal freedom and the pursuit of her personal life." If she is confident of her husband's approbation and affection and has any degree of personal serenity this will not seriously disturb her psychologic balance.

Women of the more masculine type of personality may find it hard to accept the fact of pregnancy even if deliberately elected. Women who have not completely identified with "femaleness" sometimes wish to be pregnant as a demonstration of that very attribute. By the function of reproduction such patients perhaps compensate an inherent lack, sensed if not comprehended. In any woman, however, there is some personality change after pregnancy.

Symptoms

Ordinarily, apprehensions in early pregnancy are of physical change. Even a normal patient may be disproportionately concerned with diet, for example, or may interpret any slight discomfort as menacing to her own or her child's health. Diet and weight problems produce anxiety in some patients. Many women because of restlessness, unhappiness, or boredom, or as a revolt against restrictions derive particular gratification from overeating. Later in pregnancy, when the matter of loss of figure is no longer academic, need for oral gratification may increase; this has a double import. Much has been written about the degree to which loss of figure affects the wish to be pregnant. A patient may accept the idea that she will be larger and misshapen, with resultant awkwardness and impeded activity, but it is different when the changes actually occur. The other factor in the figure-food problem is the all-important relationship with the obstetrician. The physician should inspire confidence and allay fear. With pregnant patients he may assume a function similar to that of a father. When he imposes restrictions, then, there is additional occasion for development of anxiety. Most patients sincerely desire instruction, but if approval of the person upon whom they have suddenly become dependent is contingent upon maintenance of a dietary schedule, then any departure from it is equivalent to disobedience.

Another significant symptom is that of persistent nausea and vomiting. "Morning sickness" can be attributed to a form of attempted expulsion of the fetus, related to childhood ideas of oral impregnation. Nevertheless, a physical basis may exist. According to Haas, patients who had frequent gastrointestinal disorders in childhood usually also have extreme nausea during pregnancy. So-called nervous vomiting can literally be protracted until toxic, with subsequent acidosis and liver impairment. It can, according to some investigators, also be indicative of incipient development of psychosis.

In the latter part of gestation a patient's fears are usually of another sort. Apprehensions are usually first about the baby and then about the approaching experience of labor. Patients are more immediately conscious of fetal life, concerned with normality, and curious about the sex

of the child. Besides the readiness to be relieved from the waiting period there is fear or uncertainty about delivery. In healthy adults the dread of pain exists but is subordinate to anticipation of the child. In some patients, however, the imminence of confinement increases anxiety, fears of death, resentments, or depression.

The physician and the anxious patient

The physician who attends a pregnant woman has, to a great degree, responsibility for her mental as well as physical care. Obviously he cannot know all the personality factors involved or, in many instances, the environmental circumstances into which the child will be born. His instructions and advice as to physical care will be important, and much of the help he gives the patient is determined by her initial physical examination. Inadvertently many character traits are indicated in the patient's recital of the medical history, and the alert physician can recognize potentially dangerous characteristics.

Instruction by the physician probably does not accomplish as much as was once believed. If, however, he engages the patient's interest and makes her at ease in his presence, he can also answer questions and do much to correct mistaken ideas and previous faulty advice. The patient who feels free to be candid will be less likely to worry unduly over her emotions or physical manifestations. For example, if she understands that a degree of ambivalence in reaction to the prospect of confinement is neither uncommon nor dangerous she may think less about it. Aldrich has said that a woman is expected to be of a pleasantly anticipatory turn of mind about the expected child. When she has periods of discouragement, dread of pain, and realization of her probable loss of freedom she may be frightened at her own emotions. As these are not the expected attitudes she may be ashamed of her own thoughts. The physician can sometimes afford both opportunity for ventilation and a degree of reassurance. A program of mental hygiene promotion is the best measure, and prevention of anxiety obviously preferable to alleviation. The method known as "natural childbirth" has been much advocated in this connection. This type of educational program is predicated upon the importance of ridding the patient of fear. The pregnant patient's fears can be of suffering, death, or injury to the child, and her receptivity to pain is affected by physical and psychologic factors, such as fatigue, depression, anemia, disappointment, and loneliness. According to Read, a three-sided situation develops, a fear-tension-pain syndrome, which is unnatural, and unnecessary, and which has been superimposed by civilization and ignorance. Fears bring about muscular tension. Such tension of course constricts the uterine outlet and inhibits the expulsion process. Pressure from the child on the outlet causes sensations to be relayed to the central nervous system which, according to Read, are "interpreted as pain." This chain of tension, contraction, and additional stimuli becomes cyclic, and the obvious means of prevention would be to forestall the original tension-creating fear. In the Read method this is accomplished by a planned program for the prenatal period. The patient is educated, systematically, about physiologic facts of labor and delivery and is taught methods of relaxing various muscle groups. Relaxed and without the fears that produce tension, she can, in theory, have a shortened period of labor, a minimal amount of pain, and much relief from nervousness and dread. The physician allows the patient to choose the program, and she has assurance of medical aid, anesthesia, or analgesia if required.

There are, however, contraindications to this desirable sequence of events. A significant factor is that of the patient's reason for choosing the program. Rogers says, "Every pregnancy produces a conflict between the powerful instinct to reproduce and the instinct for self-preservation, with attendant emotions of anxiety and guilt." If, in a patient with strong guilt feelings or masochistic drives, this method is chosen, it may simply represent further development of an obsessional trait. A patient may elect the method with an irrational idea of ridding herself of neurotic tendencies in an expiatory performance. Actually, then, the method can be dangerous to patients with serious personality problems. Few physicians have time for exhaustive study of patients, so that perhaps a compromise may be advisable.

If the patient has the advantages of sound advice, prenatal instruction, and assurance of medication or surgical aid if needed she may be able partially to overcome her fears. Perhaps the greatest reassurance will be provided if the physician can help the patient to accept her own emotional status and not try vainly to conform to a behavioral standard impossible to her. If the physician can help patients to modify their ideas of what is normal or ideal in behavior during confinement he will have effectively reduced one source of anxiety. Reynolds has remarked that the physician has abetted the development of anxiety if he makes the patient afraid of being afraid.

Many complications of pregnancy relate to anxiety and stress. Minimization of literal hazards does not remove them, and fear of toxemia, premature labor, hemorrhage, and fetal abnormality may produce severe anxiety with later interference in normal labor. Tension in the pregnant patient may result from defective sexual instruction, ambivalent emotions, resistance to responsibility, feelings of inadequacy, repudiation of femininity, or what Reynolds calls "the attempt to live beyond . . . emotional means." Patients who have set themselves patterns of behavior impossible of attainment can only be unhappy at their own failures. Education, explanation, and personal care are available to the anxious patient from the attending physician.

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Questions and Answers

QUESTION: What are the legal aspects of transvestism?

ANSWER: Although there are no laws by which transvestism is specifically prohibited in the United States, statutes related to disorderly conduct, disturbance of peace, or intent to defraud are sometimes invoked to apprehend persons who wear clothes of the opposite sex. These individuals are usually known to the police, but unless they commit some other offense or become public nuisances, they are seldom arrested. In some European countries, a permit is issued to the transvestite, upon medical recommendation that garb of the opposite sex is essential to the individual's mental health. Occasionally, transvestites will request surgical alteration to approximate more nearly the desired sex. Again, no specific law prohibits such procedures, but most physicians are reluctant to attempt alteration because of the mayhem statutes. The mayhem law was originally devised to prevent soldiers from being rendered incapable in performance of duty. This statute is not precisely applicable but, in most states, the mayhem law has been interpreted to include such surgical transformation. Castration by hormonal administration is not prohibited legally, but must be considered from the medical viewpoint with respect to possible carcinogenesis. Intensive psychotherapy is probably the treatment of choice for transvestites, although, according to Bowman and Engle, no instances of successful treatment have been reported.

Bowman, K. M., and Engle, B.: Medicolegal Aspects of Transvestism, Am. J. Psychiat. **113**:583 (Jan.) 1957.

QUESTION: What may be done to achieve more effective treatment of patients with chronic complaints?

ANSWER: If complaints of discomfort are continued without abnormal clinical findings, the patient's personality should be carefully evaluated. Frequently such patients have consulted one physician after another in search of some especial treatment or medication. In an effort to relieve the patient's expressed discomfort, the physician may err by overmedication, by subjective interpretation of pain, or by failure to recognize the possibility of a psychologic problem. When the problem is emotional, drugs are not usually effective, and the patient frequently omits them and consults another physician. With the recognition of a psychologic basis for the complaints, therapy would include provision for ventilation of the patient's feelings, and a consistent attitude of acceptance and understanding.

Rond, P. C.: Therepeutic Carefulness, J. Lancet **77**:9 (Jan.) 1957.

QUESTION: What is the present legal status of the epileptic patient?

ANSWER: Unfortunately, legislation that concerns epileptics has not been revised in accordance with the progressive medical understanding of the disorder. Thirteen states have laws which make marriage of epileptics a criminal offense, require or permit sterilization of patients, and include epileptics as subjects for custodial care. In many states, drivers' licenses are prohibited to patients with epilepsy, and, as yet, there has been no revision, applicable in such instances, of the workmen's compensation laws. Recognition that there is no need for such strenuous restrictions at the present time is necessary in order to achieve amendment.

French, E. G.: Epilepsy, Am. J. Psychiat. **113**:629 (Jan.) 1957.

QUESTION: How essential is estrogenic hormone therapy in treatment of patients during menopause?

ANSWER: Approximately 90 per cent of patients with menopausal symptoms may be treated without estrogenic hormone administration. Frequently the emotional problems, anxieties, and tension will be alleviated by reassurance, adequate explanation, and occasional use of mild sedation. The remaining ten per cent of patients may require estrogenic hormone therapy. Indications of this need would be inadequate response to other therapeutic measures.

Williamson, P.: Menopausal Symptoms and their Treatment, Am. Pract. & Digest Treat. **8**:79 (Jan.) 1957.

QUESTION: Is psychotherapy effective for patients with essential hypertension?

ANSWER: Moses, Daniels, and Nickerson have published a progress report after seven years of study in a ten year research program. The investigators hope, by this study, (1) to define a psychophysiological method for investigation of essential hypertension; (2) to determine the quantitative psychodynamic factors in relation to organic involvement; (3) to determine correlation between rage and anxiety states and hypertensive reaction; and (4) to attempt to obtain a five-year remission through psychotherapeutic techniques. According to their findings, feelings of rage result in blood pressure elevations of 160-200/100-130 mm., and anxiety causes elevations of 140-160/90-100 mm. The hypertensive patients studied showed a tendency to accumulate rage and anxiety feelings with inadequate release of emotions. The authors stated that in the cases treated in this study, psychotherapeutic modification was possible to the extent of two-to-six-year remissions.

Moses, L., et al.: Psychogenic Factors in Essential Hypertension, Psychosom. Med. **18**:471 (Nov.-Dec.) 1956.

Acute Alcoholism

● ACUTE ALCOHOLIC ILLNESS is a toxic condition that results from a high concentration of alcohol in the blood stream. A rate of 150 milligrams of alcohol per 100 cubic centimeters of blood is usually considered intoxication. A blood level of 300 milligram per cent produces stupor; 400-500 milligram per cent induces coma; and higher levels result in respiratory paralysis and death.

Rate of absorption, amount ingested, and the individual systemic condition will affect the alcohol concentration. Thus, the chronic alcoholic may show little outward effects even with a high blood level. During periods of stress or rage, individuals may respond to lower blood alcohol levels with violent abreactions and sometimes even with subsequent amnesia. An injury or the presence of disease may precipitate an attack. An intermittent drinker or a youthful inexperienced one can incur acute alcoholism simply by high consumption over a relatively short time.

Concomitant diseases

Much of the alcoholic patient's discomfort can be attributed to concomitant disease. Polyneuropathy, pellagra, ataxia, and amblyopia are sometimes coexistent. Cirrhosis of the liver occurs often enough in chronic alcoholic patients to warrant the assumed association. The incidence is estimated at eight per cent, as contrasted with one per cent in nonalcoholic patients. Male alcoholics in middle life are most likely to be affected. Alcoholic myocardosis and nutritional heart disease associated with hepatic insufficiency are other clinical manifestations of alcoholism.

The concomitant diseases can all contribute secondarily to abnormal mental functioning. Sexual impotency may lead to sexual aberrations and paranoid manifestations. Dementia, Korsakoff's psychosis, and Wernicke's encephalopathy are also associated with alcoholism.

Treatment

An individual in a state of acute alcoholism requires immediate medical attention, and preferably, hospitalization. Removal of a patient from usual surroundings is considered beneficial. However, lack of available facilities and sufficient trained personnel may sometimes make hospitalization impracticable.

Generally, relief from dehydration, correction of nutritional deficiencies, and attention to any concomitant disease are the first considerations. The choice of treatment obviously depends upon the patient's immediate needs. If the patient is comatose, gastric lavage may be performed to remove residual alcohol. Metabolism of assimilated alcohol may be accomplished by intravenous administration of dextrose and saline solutions. A mixture of caffeine and sodium benzoate may be given as a stimulant, and specific treatment begun when the patient regains consciousness.

If the patient is not comatose, but is somnolent or depressed, drugs such as caffeine and sodium benzoate, dextro amphetamine, amphetamine, methylphenidate hydrochloride, or pipradrol hydrochloride will be counteractive. However, unless the symptoms of depression are severe, the patient will usually respond without drug therapy as soon as the alcohol is metabolized. Dilantin® may be given if there is a possibility of convulsions. Patients with convulsions may be treated with thiopental sodium or mephenesin. Continued control of convulsions may be achieved by the administration of Dilantin.

A state of acute alcoholism which is characterized by hyperactivity, excitability, nausea, and vomiting has, in the past, been resolved by the use of paraldehyde, chloral hydrate, or barbiturates. Some authorities continue to recommend these drugs as most effective, while others believe that they are contraindicated because of their addictive properties. Administration of cortisone preparations has been reported as successful in treatment of the agitated patient. The use of this drug is based on the fact that prolonged stress causes adrenal cortex exhaustion and subsequent depletion of the store of glycogen. For the acute alcoholic patient, intravenous administration of 50 mg. of hydrocortisone in 1,000 cc. of 5 per cent glucose, or 50 mg. of hydrocortisone hemisuccinate given intravenously usually provides prompt relief from severe withdrawal symptoms. Cortisone may be given by mouth in doses from 25 mg. to 50 mg. every six hours for 24 to 48 hours, after which the dosage may be reduced according to symptoms. Hydrocortisone may also be administered orally in a similar manner.

Many investigators advocate the use of tranquilizing drugs as most beneficial. The tranquilizers act as central nervous system depressants and produce relaxation through reduction of tension. They also alleviate nausea and although not sleep-inducing, produce sufficient relief from symptoms to provide comfortable rest. One of several tranquilizing drugs may be chosen for administration to the patient in an acute alcoholic state. Drugs may be given interchangeably, and the choice will de-

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Chronic Alcoholism

THE TERM CHRONIC ALCOHOLISM denotes the group of physical and psychological changes that result from prolonged, excessive use of alcoholic beverages. Addiction to alcohol can result from social drinking, and is usually considered indicative of personality disturbance. The alcohol does not of itself produce disease, but alcoholism can, however, have specific clinical manifestations.

Investigators from the Laboratory of Applied Physiology at Yale estimate that of one hundred chronic drinkers, there are forty who are neurotic, ten who are feeble-minded, and that the remaining fifty drink to escape unpleasant situations. Other authorities believe that the percentage of neurotics should be much higher.

Etiology of alcoholism

Although the possibilities have been intensively studied, no organic basis for the development of alcoholism has been proved. No positive evidence has been found to support the theory that heredity is a factor. Statistically it can be demonstrated that children of alcoholic parents more often become alcoholics than children of normal parents. However, this result may only indicate that because of poor environment there are more instances of maladjustment.

Alcoholism is interpreted as a symptom of underlying emotional disturbance. There seems to be no typical alcoholic personality, although certain common factors have been distinguished in research studies. Emotional frustration, unmet dependency needs, failure to establish independence of a dominant parental figure, and subsequent resentment are commonly apparent from case histories. Lack of ability in childhood to satisfy parental demands and consequent rejection may initiate feelings of inadequacy and guilt.

Many chronic alcoholics apparently develop oversensitivity and inability to resolve conflicting inner drives. Psychosexual abnormalities are not uncommon and paranoid trends are also often evident. The chronic alcoholic seems basically to want a passive existence. In addition, the alcoholic often refuses to recognize his limitations and, therefore, constantly subjects himself to emotionally hazardous situations. Failure to develop the ordinary protective mechanisms seems to be a determinant in the etiology of alcoholism.

In adolescence, drinking can represent an act of defiance of parents and society. The need for this type of defiance intensifies in a society which accepts adults' drinking but disapproves strongly of drinking by adolescents. Most addicts start drinking in early youth or in the twenties. They may continue without appreciable effect on their individual economic or social conditions until the crucial ages of forty to sixty years.

Emotional stresses have a strong impact on the immature personality of the incipient alcoholic. Guilt, anxiety, fear, self-consciousness in social situations, and tension are intolerable to the poorly integrated personality. The sedative effect of alcohol becomes progressively more important in the individual's necessary contacts with the unpleasant realities.

Personality of the adult alcoholic

Jellinek offers a composite picture of the chronic alcoholic in whom the first symptoms of disease are beginning to be evident. He is forty-five years old, male, in poor health, suffering from malnutrition, anemia, enlarged liver, and lacking in muscle tone. He consumes an approximate pint of whiskey every day and has done so for fifteen or more years. However, addiction to alcohol occurs among housewives, teachers, ministers, business men, and other responsible members of the community.

Usually, the middle years of life are the decisive ones in chronic alcoholism. Unless treatment is undertaken, the degenerative process is rapid. Economic, social, and environmental factors no longer affect its course. Most therapists consider that individuals who do not display signs of chronic alcoholism until middle life have enough emotional stability and social experience to be good subjects for rehabilitation. Individuals of relatively high economic strata and with fairly normal home backgrounds are more likely to seek treatment voluntarily and to take positive action than the skid row type of addict.

Immature emotional attitudes, however, continue in most adult alcoholics. Although such patients are usually egotistical, they are inept in personal relationships. In public life, they may be accepted as pleasant and affable, but at home are more often morose, irritable, and unstable. The need for uncritical affection and constant approbation remains the primary concern. Customarily an alcoholic blames his failures on outside influences or bad luck rather than on his own inadequacies. Rejection by those from whom he expects sympathy and protection is intolerable to him, as he cannot accept the idea that his defections are in any way responsible. As the disease intensifies, he may accuse his wife of infidelity, develop incestuous feelings toward a daughter, or show homosexual ten-

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ACUTE ALCOHOLISM

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pend upon individual reaction. Habituation to these drugs has been reported by some investigators but addiction is less likely than it is with the older medications, since the tranquilizers may be alternated.

Chlorpromazine is rapid in action, and may be given in doses of 25 to 100 mg. every four hours. This drug potentiates the sedative effect of alcohol, and may produce severe hypotension within a half hour after intramuscular administration. Jaundice and allergic dermatitis have also been reported as resultant effects. An antihistiminic may be given simultaneously to reduce allergic reactions.

Reserpine may be given in doses of 0.25 to 1 mg. every four hours. The action is slower than that of chlorpromazine but is longer lasting. This drug may also produce hypotension although the reaction is not frequent. Congestion of nasal passages may sometimes occur, and may be counteracted by an antihistiminic.

Meprobromate may be given in doses of 400 mg. once, twice, or four times daily. No adverse effects, including hypotension, have been reported from the use of this drug, and patients may be maintained on smaller doses for indefinite periods.

Sparine® has a rapid effect and may be given in doses of 25 to 200 mg. three or four times a day. The action of Sparine is similar to that of chlorpromazine without some of the latter's adverse effects. Intramuscular injection produces little local tissue reaction, and no untoward systemic reactions have been proved.

Many investigators have reported successful treatment of patients in a state of acute alcoholism by the use of tranquilizing drugs exclusively. Large doses may be necessary through the acute phase, but the patient is able to maintain awareness and to receive relief from tension.

Rehabilitation

An opportunity for long range rehabilitation, of course, is not possible until physical distress is lessened. At this time the attitude of family, physician, and hospital staff is of paramount importance. Long range rehabilitation requires definite plans for abstinence and some form of psychotherapy. Rehabilitation depends upon acceptance or alteration of the situation by an enlightened society. The possibility of an educational program similar to those conducted about tuberculosis and syphilis is a frequent subject of discussion. Most medical authorities feel that education of the public would aid in the reduction of the problem. Interest, candor, and instruction, from the physician, can be of appreciable importance to the alcoholic patient.

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CHRONIC ALCOHOLISM

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dencies. Also characteristic is refusal to admit dependency on alcohol. An alcoholic will consistently minimize both the compulsive factor and the amount of consumption. By the time that physical changes are manifest, addiction has both physiological and psychological bases, and abstinence is literally impossible.

Most authorities believe that total temperance is necessary for rehabilitation. The therapist finds this a difficult problem, since total prohibition suggests disapproval and makes objectivity hard to attain. The relatively high success of Alcoholics Anonymous has been attributed to their acceptance of the necessity for abstinence, along with a realistic appraisal of the difficulty of it.

Possibility of recovery

Estimates vary greatly as to the number of patients who recover or improve after therapy. The most common figures are ten per cent recovery, fifty per cent improvement, and forty per cent unchanged. Alcoholics Anonymous reports recovery in fifty per cent of individuals who make conscious effort, and improvement in the other fifty per cent, although this organization is admittedly casual and optimistic in its statistics. The National Committee on Alcoholism reports that thirty-nine per cent of patients referred to physicians, hospitals, clinics, and Alcoholics Anonymous remain sober for periods of one and a half to five years.

These are compelling figures when measured against those often quoted to show the economic costs and the human problems attendant on alcoholism. Jellinek, in 1948, estimated that there were approximately 3,800,000 alcoholics in the United States. The magnitude of the problem and the realization that it can be reduced by scientific and medical methods are increasing the attention to research. Much further information about chronic alcoholism is necessary for consistently successful rehabilitation, and, ideally, for prevention.

Suggested Reading

Haarer, J. G.: A Physician's Report on the Yale Summer School of Alcohol Studies, J. Michigan State M. Soc. **54**:822 (July) 1955.

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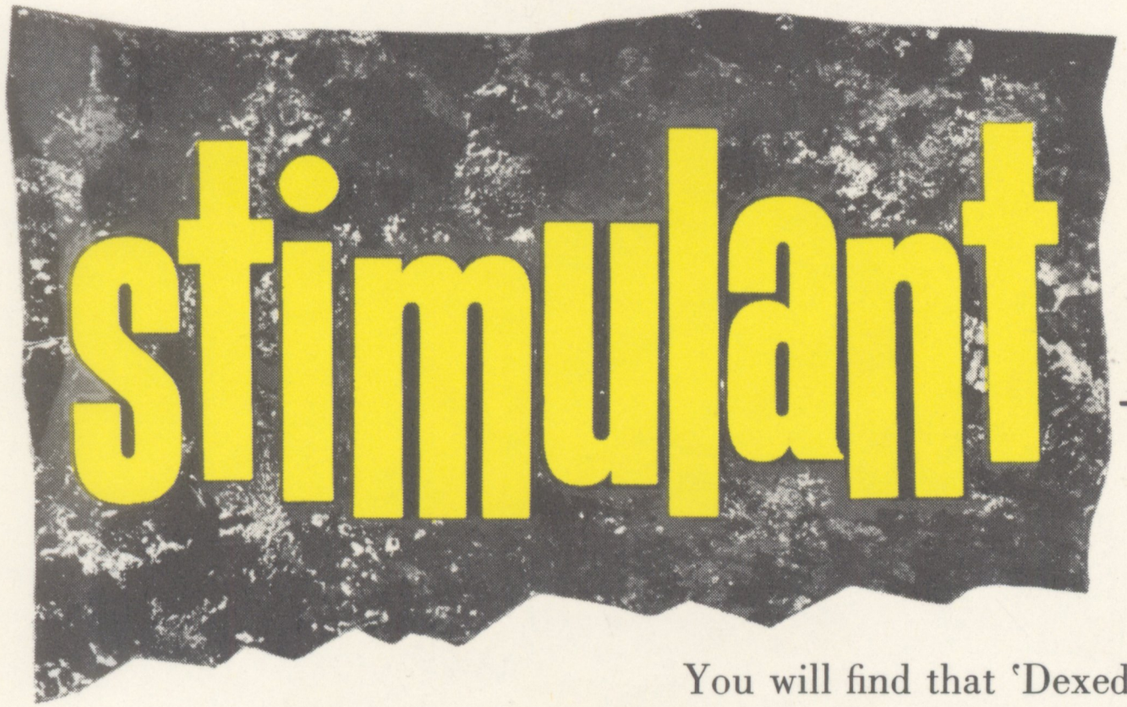

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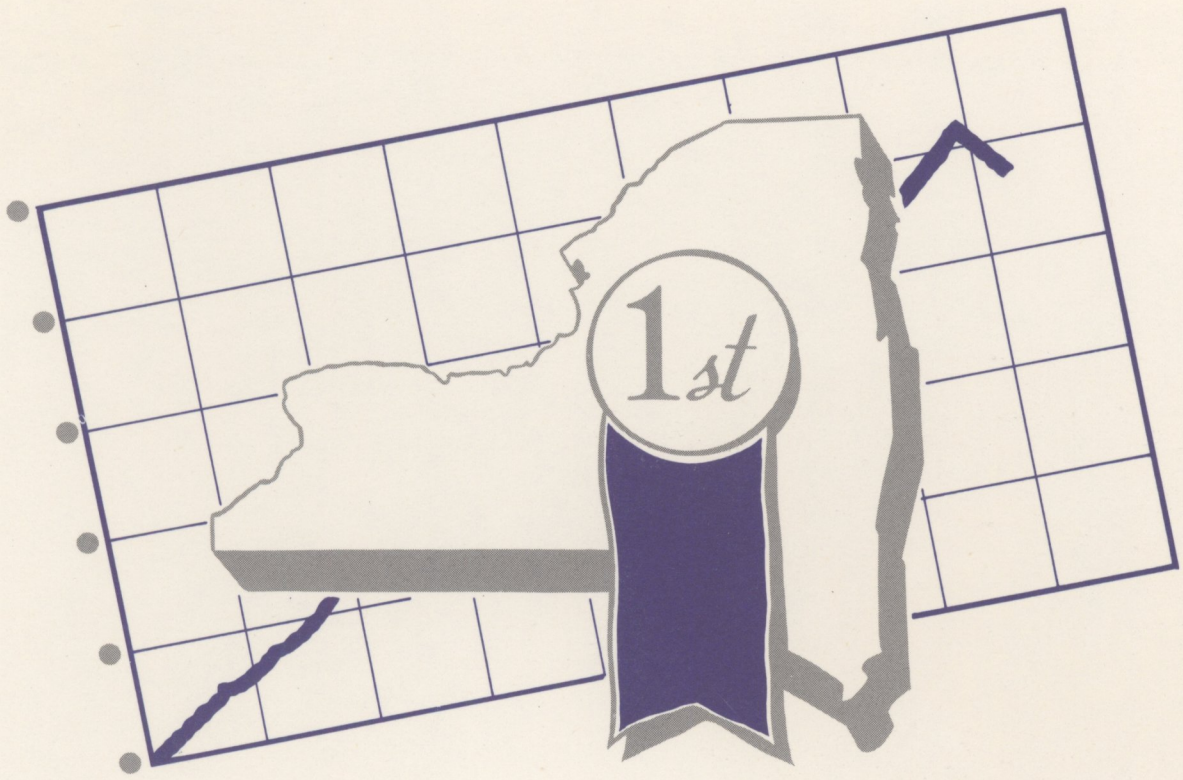

National Mental Health Committee Report

In 1956, for the first time in history, there was a decrease in the number of hospitalized mentally ill patients in state institutions. The nationwide figure is estimated to be 7,000 fewer hospitalized patients at the close of 1956 than at the close of 1955, despite the fact that there were 8,000 more patients admitted. In contrast, the national average increase in mental hospital population had been 9,400 patients per year during the previous ten years.

A number of factors were involved in the decrease of 1956; significant among these were the greater state legislature fund appropriations. For example, these additional funds made possible the employment of more and better qualified personnel who were able to provide intensive psychotherapy. This, in turn, hastened the release of hospitalized patients and made feasible treatment on an out-patient basis.

The National Mental Health Committee has compiled a report of individual state expenditures of appropriated funds to show how effectively the funds were used. An impressive reply was that of Paul H. Hoch, Commissioner of Mental Health, Department of Mental Hygiene, New York. Hoch reported that a total of 210.5 million dollars had been provided by the New York state legislature. Of this amount, 162.3 million was used for operating expense, 6.7 million for support of local programs, and the remainder of 41.5 million for such assets as buildings and property.

Further enumeration of New York's expenditures included the following:

Research	$2,500,000
Training of personnel	3,000,000
Experimental work	3,000,000
Personnel to provide intensive therapy	1,100,000
Two day-hospital units	156,486
Four geriatric units	111,084
Tranquilizing drugs	1,500,000
After-care clinics	882,000

Hoch further reported that instead of New York's expected increase of 2,400 hospitalized patients in 1956, there was a decrease of 600. Reports from some of the other states, while not as striking as the New York report, have also shown a decrease in the number of resident patients in state mental hospitals.

The Committee emphasized the importance of state legislative fund appropriations. If the amounts continue to be increased to facilitate intensive treatment and rehabilitation of mentally ill patients, there should also be a continued decrease in the number of hospitalized patients. This, in turn, would eventually diminish the cost of care, and, finally, would be an actual saving in total expenditure.

Copies of the report may be obtained by writing to National Mental Health Committee, 1129 Vermont Avenue, N. W., Washington, D. C.

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in the cocoon of its own thoughts,
and dwell a hermit anywhere."
J. R. Lowell.